

Purpose:

MED - Medical Support Pre-Procedure Member Eligibility

Purpose: Medical services will process provider request for the procedure and verify member eligibility.

Identification of Roles:

Review Assistant – (RA) – receives documents through OnBase by fax or mail and distributes to review coordinator through workflow.

Review Coordinator – (RC) receives documentation through OnBase pre-procedure lifecycle.

Performance Standards:

- Complete 95 percent requests without PR within 10 business days, 100 percent within 15 business days of initial receipt of complete PA and supportive documentation.
- Complete 95 percent with PR within 15 business days and 100 percent within 20 days of initial receipt of complete PA and supportive documentation.
- PA requests with requests for more information process 95 percent no earlier than 45 days and no later than 60 days. Complete 100 percent within 60 days from initial receipt.

Path of Business Procedure:

Step 1: The prior authorization request and supporting documentation will be scanned into OnBase.

Step 2: The mailroom will data enter assigned keywords to the document:

- a. Document Control Number (DCN)
- b. Archive Box
- c. Batch number if document was mailed into medical services

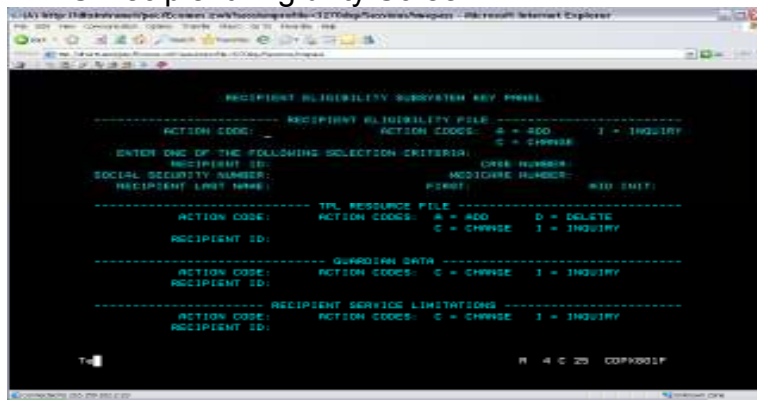
d. Document type of correspondence

Step 3: The RA and or RC will log the pre-procedure to the RC for review and send the review to the review queue

Step 4: The RC will log into the Medicaid Management Information System (MMIS), select File 10 and enter "I" for action code and verify the member's:

- a. State Identification Number (SID)
- b. First and last name
- c. Date of Birth
- d. Address
- e. Eligibility

MMIS Recipient Eligibility Screen



Step 5: The RC will determine eligibility and determine if member has a third party liability (TPL) or if primary payor is Medicare by using file 10 in MMIS.

Step 6: The RC will complete a review of the medical record if Medicare is primary eligibility and the request is for gastric bypass.

Step 7: The RC will review if the member is going to have services completed at a Medicare designated Center of Excellence (CoE) in Bariatric Procedures.

A review of the submitted documentation will be completed if Iowa Medicaid will be expected to pay any portion of the service provided.

Step 8: If the requested service is for an organ transplant and the facility is certified by Medicare to complete that service and the member has both Medicare Part A and B then a review by Iowa Medicaid is not required.

Step 9: The RC will check with the facility prior to reviewing a Medicare primary member request, as Medicare may not pay on some diagnosis codes.

Forms/Reports:

N/A

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Srv Medical Support Pre-Procedure Referral Retrieval

Purpose: Medicaid members scheduled for a specific procedure or all specified diagnoses are required to be prior authorized before admission. Organ transplant and gastric bypass procedure reviews are completed for members with traditional Medicaid and MediPASS coverage. Any members that are under the 531 (Iowa Marketplace Choice Plan or 501 (Iowa Wellness Plan) or an HMO, are not reviewed.

Identification of Roles:

Review Assistant – (RA) – receives documents through OnBase by fax or mail and distributes to review coordinator through workflow.

Review Coordinator – (RC) receives documentation through OnBase Medical Services fax and/or correspondence queue.

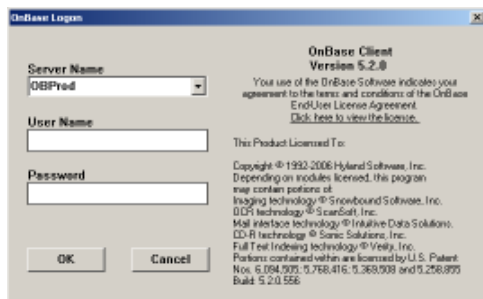
Path of Business Procedure:

Step 1: The review assistant (RA) and/or review coordinator (RC) will access OnBase daily for referrals.

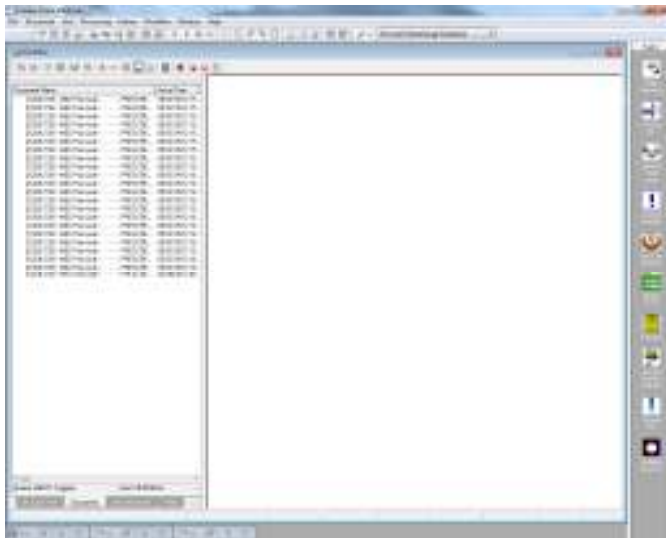
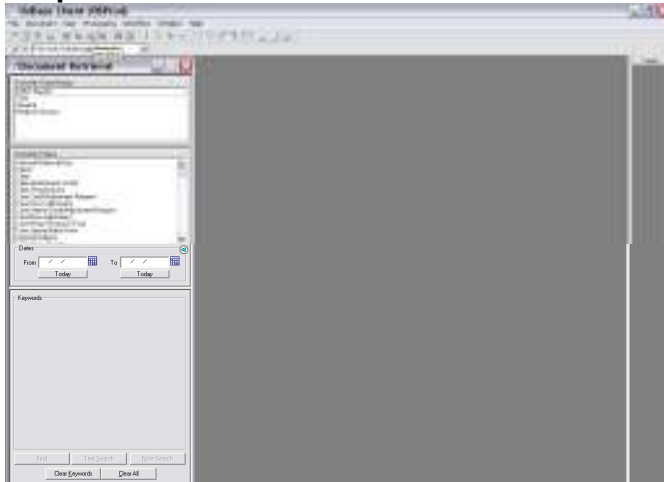
Step 2: The RA and/or RC will log into OnBase.

Step 3: Enter user name and password.

Step 4: Click OK.



Step 5: Click on Workflow icon to access folders



Click work folder Med11

Step 6: The RA and/or RC will receive the document in MED11 logging.

Step 7: The RA and/or RC will review the document to determine if the request is a bariatric or transplant request.

Step 8: The RA and/or RC will complete the enter keywords task and data enter:

- a. Provider Identification Number (NPI)
- b. Member State Identification (SID) Number
- c. Date of Service
- d. Type of PA Request
- e. PA Sub-type
- f. Designated RC

Step 9: The RA will send to the RC for review.

Step 10: The RC will review the information and ask for any additional information needed to complete the review.

Forms/Reports:

N/A

RFP Reference:

6.2.5

6.2.5.1

6.2.5.2

6.2.5.3

Interfaces:

MMIS

OnBase

Attachments:

N/A

MED - Medical Support Pre-Procedure Review Request and Supporting Documents

Purpose: To ensure the necessary documentation to make a determination for a procedure is available for review.

Identification of Roles:

Review Coordinator (RC) - reviews medical documentation.

Review Assistant (RA) - provides clerical support.

Physician Review (PR) - provides determination for authorizations regarding questioned medical necessity.

Performance Standards:

- Complete 95 percent requests without PR within 10 business days, 100 percent within 15 business days of initial receipt of complete PA and supportive documentation.
- Complete 95 percent with PR within 15 business days and 100 percent within 20 days of initial receipt of complete PA and supportive documentation.
- PA requests with requests for more information process 95 percent no earlier than 45 days and no later than 60 days. Complete 100 percent within 60 days from initial receipt.

Path of Business Procedure:

Step 1: The review coordinator (RC) will process requests within 15 calendar days. If the request is urgent the determination must be made and completed within 72 hours.

Step 2: The following information is required to complete a pre-procedure review:

- a. PA Form
- b. Hospital or location of intended admission or procedure
- c. State Identification (SID) Number
- d. Name of member's Primary Care Physician
- e. Attending or surgical physician's first and last name
- f. Diagnosis Code and procedural code being request
- g. Lab and X-ray results if pertinent to the request
- h. History – chief complaint, symptoms, outpatient treatments, physical findings, duration of problem, home medications, and any other pertinent information
- i. Prospective date of the invasive procedure
- j. The member's address, including the zip code, must be provided
- k. All bariatric requests must be accompanied by a psychological evaluation
 - 1.
 2. and transplants must have a psychological and/or social work evaluation.

Step 3: The RC will review submitted documentation to insure that the request is complete.

Step 4: If there is a request for a pre-procedure review and the required information is not submitted, the RC will complete a request for additional information and send it to the requesting provider. Only the information necessary to approve the procedure will be requested.

Step 5: Once the request for additional information letter is completed the RC will save the changes, and click the pend task to send the additional information letter to the provider.

Step 6: The request for additional information letter will automatically transfer to the "to be pended" queue for the letter to be faxed to the provider.

Step 7: The RA and/or RC will pend the request in OnBase until additional information is received.

Forms/Reports:

Transplant Additional Information Letter

xx/xx/xxxx

Transplant Contact
Hospital Name
Address
City/State

Re: Member Name- Autopop
DOB: xx/xx/xxxx-Autopop SID: xxxxxxxx-Autopop

Dear Transplant Contact:

In order to correctly process the request for organ transplant, additional information is required. The following checked items indicate information required to request or re-new a transplant approval:

- ☐ Hospital or location of intended procedure
- ☐ Member Iowa Medicaid number
- ☐ Attending physician's name
- ☐ Procedure and CPT
- ☐ Diagnosis and ICD9:
- ☐ History and chief complaint (include symptoms and duration of the problem)
- ☐ Current medical/surgical therapies attempted or given consideration
- ☐ Other medical history or problems
- ☐ Laboratory and X-ray studies and results performed (outpatient, inpatient, and dates)
- ☐ Current medications, dosage, frequency, and the length of time administered.
- ☐ Medical assessment documentation that indicates that the member presents a reasonable risk for surviving the transplantation surgery and will be able to tolerate immunosuppressive therapy.
- ☐ Documentation of approval by the Center's Transplant Board
- ☐ Copy of the treatment protocol that will be utilized.
- ☐ Additional documentation is needed as follows:

Please attach the above checked items to this letter and return to the Department of Human Services, Iowa Medicaid Enterprise, Medical Services Pre-procedure Review, PO Box 36478, Des Moines, IA 50315, or fax to 515-725-1356 within 10 calendar days.

Thank you for your prompt response. If you have any questions regarding this request, please call Medical Services Pre-procedure Review locally at 256-4623 or 800-383-1173.

Iowa Medicaid Enterprise
Medical Services
Pre-procedure Review

Bariatric Additional Information Letter

xx/xx/xxxx

Bariatric Coordinator
Bariatric Program Name
Address

City, State

Re: Member Name- Auto-populate
DOB: xx/xx/xxxx-Auto-populate SID: xxxxxxxx-Auto-populate

Dear :

In order to correctly process the attached request for prior authorization of a bariatric procedure, additional information is required. The following checked items indicate information required:

- ☐ Member Iowa Medicaid number
- ☐ Member date of birth
- ☐ Provider Number
- ☐ CPT – Procedure code
- ☐ ICD9 - Diagnosis code
- ☐ Current height, weight, and/or BMI
- ☐ Documentation of medical necessity
- ☐ Documentation of six months of a medically supervised diet
- ☐ Current psychiatric or psychological evaluation
- ☐ Additional documentation is needed as follows:

Please attach the above checked items to this letter and return to the Department of Human Services, Iowa Medicaid Enterprise, Medical Services Pre-procedure Review, PO Box 36478, Des Moines, IA 50315, or fax to 515-725-1355 within 10 calendar days.

Thank you for your prompt response. If you have any questions regarding this request, please call Medical Services Pre-procedure Review locally at 256-4623 or 800-383-1173.

Iowa Medicaid Enterprise
Medical Services
Pre-procedure Review

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Interfaces:

MMIS
OnBase

Attachments:

Attachment A: Transplant Review Workflow
Attachment B: Bariatric Review Workflow

MED - Medical Support Pre-Procedure Additional Information Received

Purpose: New information received will be completed within 15 calendar days with a one-time 15 calendar day extension for additional information.

Identification of Roles:

Review Coordinator (RC) - reviews medical documentation.

Review Assistant (RA) - provides clerical support.

Physician Review (PR) - provides determination for authorizations regarding questioned medical necessity.

Path of Business Procedure:

Step 1: When the additional information is received from the provider, the information is attached by the assigned prior authorization (PA) number and the document is transitioned back to the review coordinator (RC) review queue.

Step 2: If new information is being sent in on a previously denied request, a new PA number will be generated on the new information. A PA cannot be technically denied until the request is older than 45 days.

Step 3: If the requested information is not received the document will automatically transition to follow up with provider queue.

a. If the request is at least 45 days old, the request is technically denied.

Step 4: All pre-procedure requests have to be reviewed by PR.

Forms/Reports:

N/A

Interfaces:

Rev. 6/14

OnBase

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

MED - Medical Support Pre-Procedure Physician Review

Purpose: When the review coordinator (RC) is unable to determine medical necessity the RC will send the case to physician review. All bariatric and transplant reviews require peer review.

Identification of Roles:

Review Assistant (RA) – prepares medical information for physician reviewer.

Review Coordinator (RC) – reviews medical record and presents findings to physician reviewer.

Manager – provides direction, training, and oversight in pre-procedure process.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation.

Path of Business Procedure:

Step 1: The RC will collect all information and send to the selected Peer Reviewer (PR) from the transplant review list located at Medical Services\Medical Support\Pre-procedure\Transplant Reviewers List. Whenever possible the physician reviewer should be of the same specialty and practice as the attending.

- a. The timely process of the physician review is critical to minimize interruption of the admission process.

Step 2: The RC will complete the summary findings; send the cover letter and physician rationale form to the PR by fax or e-mail.

Step 3: For transplant reviews the PR is expected to complete and return the review within five days.

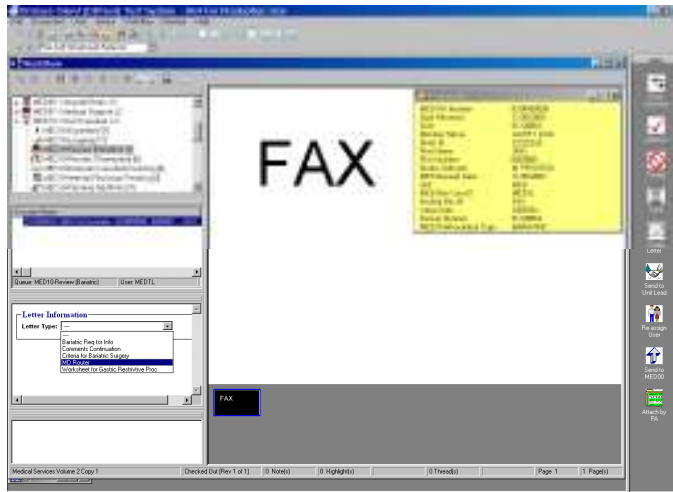
- a. If PR is not received in five business days, the RC will contact the PR by telephone to inquire if review can be completed within the next 24 hours. If the PR is unable to complete the review within 24 hours the RC will select another PR within 24 hours.
- b. The Medicaid Medical Director (MMD) may be asked to coordinate with the PR to facilitate a timely review.

Step 4: The RC reviews all gastric bypass/surgical weight loss procedures for medical necessity on a pre-procedure basis and PR is mandatory.

- a. Supporting medical record documentation must accompany all requests for gastric bypass review.

Step 5: Once the RC has received the documentation, a MD router will be prepared for the MMD by completing the create letter task. (Only peer reviewers make denial decisions. Peer reviewers include licensed health care professions in the same category as the attending provider. Denials made by the CAMD will be reviewed by the MMD or other licensed physician.)

Create Letter Screen Shot



MD Router Template



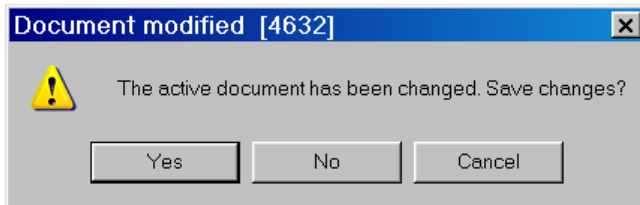
Step 6: When the internal MD router is completed, the RC will “X” out of the document and save changes

Step 7: If the transplant router is used, the RC will use the create letter task and select transplant router.

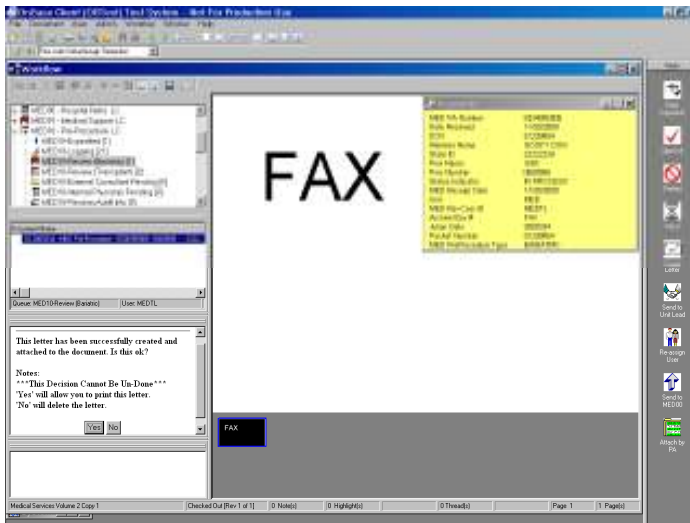
Transplant MD Router



Step 8: After the transplant router is completed, the RC will “X” out of the document and save changes.



Step 9: The RC will then see the following screen and will answer “yes” if the letter is to be generated.



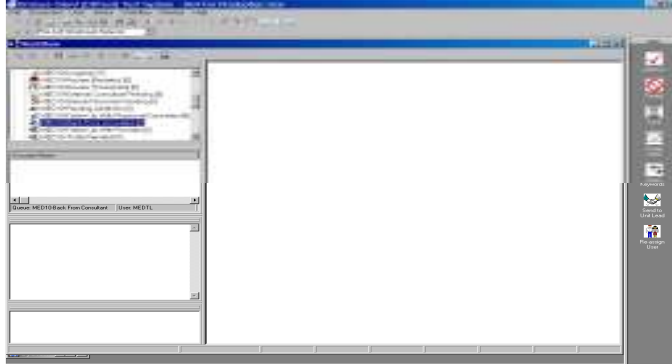
Step 10: The RC will update the pend task and send to the PR automatically transferring to the internal physician pending queue or the external consultant pending queue, depending on which router is used until the PR has been completed.

Step 11: The internal PR will complete and return the review within 72 hours.

Step 12: The external PR will have five business days to complete and return the review. Following receipt of the PR's determination back into the logging queue from the external PR, the RA and/or RC will complete the phys/con task by attaching to the PA number, entering the PR name, time spent in minutes on the review and the date of the review.

Step 13: The completed review by the PR will pend to the "back from consultant" queue.

Back From Consultant Screen



Step 14: Following receipt of the PR's determination, the RC will enter the decision into a PA form for the member, provider and facility representative.

Step 15: Only a PR can make denial decisions. Denial decisions are sent to the member by Notice of Decisions (NOD's) generated from MMIS.

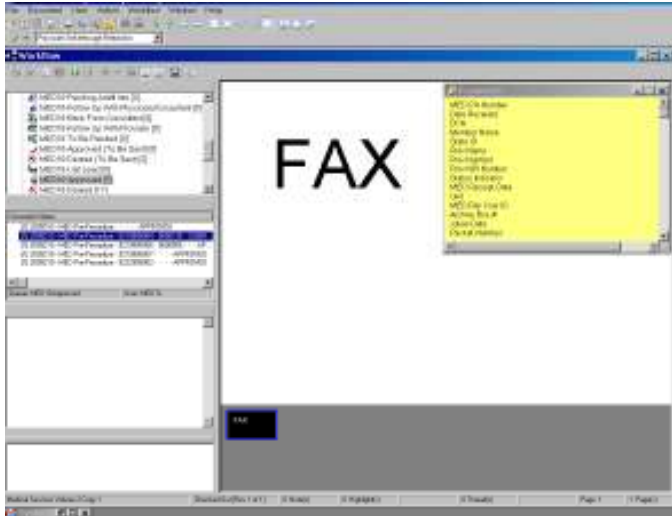
Step 16: Notice of the availability of the peer-to-peer conversation is included on the Iowa Medicaid Enterprise (IME) website <http://www.ime.state.ia.us>, click on Providers, Important Provider announcements, Peer-to-Peer Conversation. The manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances outside of Medical Services' control.

Step 17: Following the review, the RC will enter the reviewer's determination in Medicaid Management Information System (MMIS).

Step 18: The RC will notify the provider who initiated the review by a copy of the prior authorization form faxed.

Step 19: Once document has moved, the RC will fill in the PA form with the determination result and update MMIS file 12.

Step 20: The RC will complete the approved/denied task.



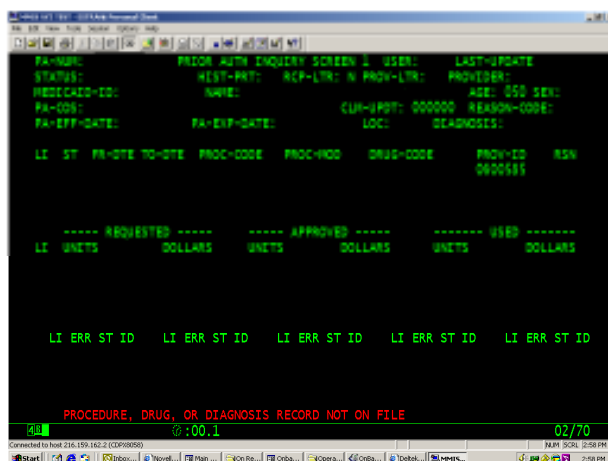
Step 21: If the transplant is approved, the document will automatically be moved into the approved queue where it will remain until the transplant has occurred or a year has passed and Medicaid has not been notified of transplant date.

Step 22: If the bariatric request is being denied a copy of the denied PA, and appeal rights are sent to the member. A copy of the denied PA is sent to the requesting provider,

Step 23: Approval decisions may be reversed if additional information is received that contraindicates continued approval by re-inserting the PA into OnBase.

Step 24: The RC will data enter a PA into MMIS.

MMIS PA Approval Screen



Forms/Reports:

N/A

RFP Reference:

6.2.5

6.2.5.1

6.2.5.2

6.2.5.3

Interfaces:

MMIS

OnBase

Attachments:

Attachment C: Physician Review Workflow

Med - Srv Medical Support Pre-Procedure Appeals Determinations

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of decision letter by contacting the local department of human services (DHS) office, by writing a letter to DHS Appeals Section or by filing on line at <http://dhs.iowa.gov/appeals/appeal-a-dhs-decision>. The notice of decision letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings.

Identification of Roles:

Review Assistant (RA) – provides program support.

Review Coordinator (RC) – performs assessments and provides education to members regarding care alternatives.

Manager – provides training and oversight in the field, tracks performance standards, produces reports for medical services and conducts internal quality control for review decisions.

Performance Standards:

- Performance standards not specified for this procedure.

Path of Business Procedure: For specific operational procedures related to appeals completed by Medical Services on behalf of DHS, see Med Srv Policy Support Appeals at IME Universal/Operational Procedures/Medical Services.

Forms/Reports:

N/A

Rev. 6/14

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Interfaces:

MMIS
OnBase

Attachments:

N/A

MED - Medical Support Pre-Procedure Internal Quality Control

Purpose: To provide continuous quality improvement to the pre-procedure functions, meet all performance standards and complete all required reports.

Identification of Roles:

Manager – Coordinates Internal Quality Control (IQC) and reporting and oversees work to meet performance standards.

Performance Standards:

Performance standards not specified for this procedure.

Path of Business Procedure:

Step 1: The manager will track and report all performance standards in a format approved by the Department of Human Services (DHS).

Step 2: The manager and/or the review coordinator (RC) will compile summary of procedures on a quarterly basis for inclusion in the Prior Authorization Quarterly Narrative report. This report will include the following information:

- a. Number received
- b. Number adjudicated
- c. Number non-adjudicated
- d. Number in process
- e. Number approved
- f. Number denied
- g. Percent denied

Step 3: The manager and/or RC will provide a monthly detail listing of pre-procedure denials.

Step 4: The manager and/or RC will provide a quarterly detail listing of pre-procedure requests.

Forms/Reports:

Monthly, quarterly and annual as directed by the Department of Human Services.

RFP Reference:

6.2.5

6.2.5.1

6.2.5.2

6.2.5.3

Interfaces:

MMIS

OnBase

Attachments:

N/A

MED - Medical Support Pre-Procedure Disruption of Business Plan

Purpose: To provide procedures for the continuation of business in the event of inability to utilize electronic programming.

Identification of Roles:

Review Coordinator (RC) – responds to pre-procedure requests, verifies eligibility and enters data elements on pre-procedure spreadsheet. All activities will be noted on the manual-tracking log.

Review Assistant (RA) - receives pre-procedure request, enters on spreadsheet, routes to the appropriate RC and sends notices to providers as needed. All activities will be noted on the manual-tracking log.

Manager – provides direction, training and oversight in pre-procedures.

Path of Business Procedure:

Step 1: The review assistant (RA) will receive pre-procedure request via fax or mail.

Step 2: Upon pre-procedure request, RA will assign a pre-procedure PA number on prior authorization form composed of a unique ten-digit number composed of the last digit of the year, three-digit Julian date, a three-digit pre-procedure type number and a four-digit document number (YJJJ955####).

Step 3: The RA will enter data in pre-procedure spreadsheet including 1-18 of the following data elements for pre-procedures:

- a. Date Received
- b. Review coordinator name (RC)
- c. PA Number (Pre-procedure number)
- d. Pre-procedure Type
- e. Date Span
- f. Provider Number
- g. Provider Name
- h. Member ID #
- i. Member Name
- j. Date out for Additional Information
- k. Dates of Nudge Requests
- l. Date Additional Information Returned
- m. Date Sent To Consultant
- n. Date of Nudge for Consultant
- o. Date Returned from Consultant
- p. Time spent by the consultant
- q. Disposition
- r. Comments

Step 4: The RA will forward pre-procedure request to the appropriate RC.

Step 5: The RC will complete eligibility and medical review as outlined in pre-procedure procedures.

Step 6: The RC will complete additional information requests and physician/consultant reviews utilizing form templates in Microsoft Word.

Step 7: The RC will complete modification or denial notice of decisions (NODs) utilizing form templates in Microsoft Word.

Step 8: The RC will enter data elements 10-18 on the pre-procedure spreadsheet.

Step 9: The RC will return adjudicated pre-procedure request form to RA.

Step 10: The RA will fax or mail completed pre-procedure request form and NODs, if applicable.

Step 11: The RA will file paper copies of pre-procedure Request form by provider name.

Step 12: The RA will enter data into OnBase when system returns to function.

Interfaces:

MMIS
OnBase

RFP Reference:

6.2.5

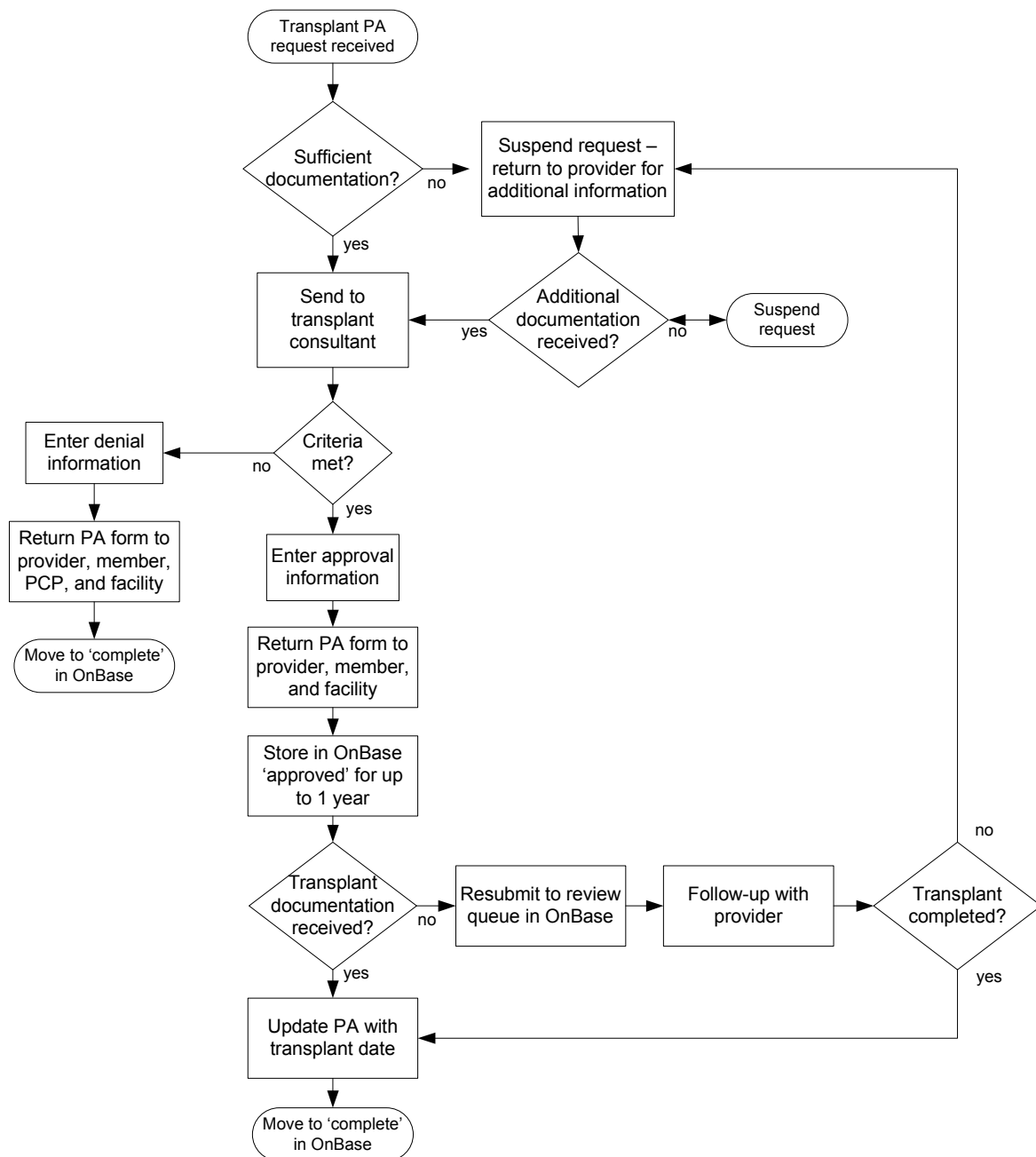
6.2.5.1

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6.2.5.3

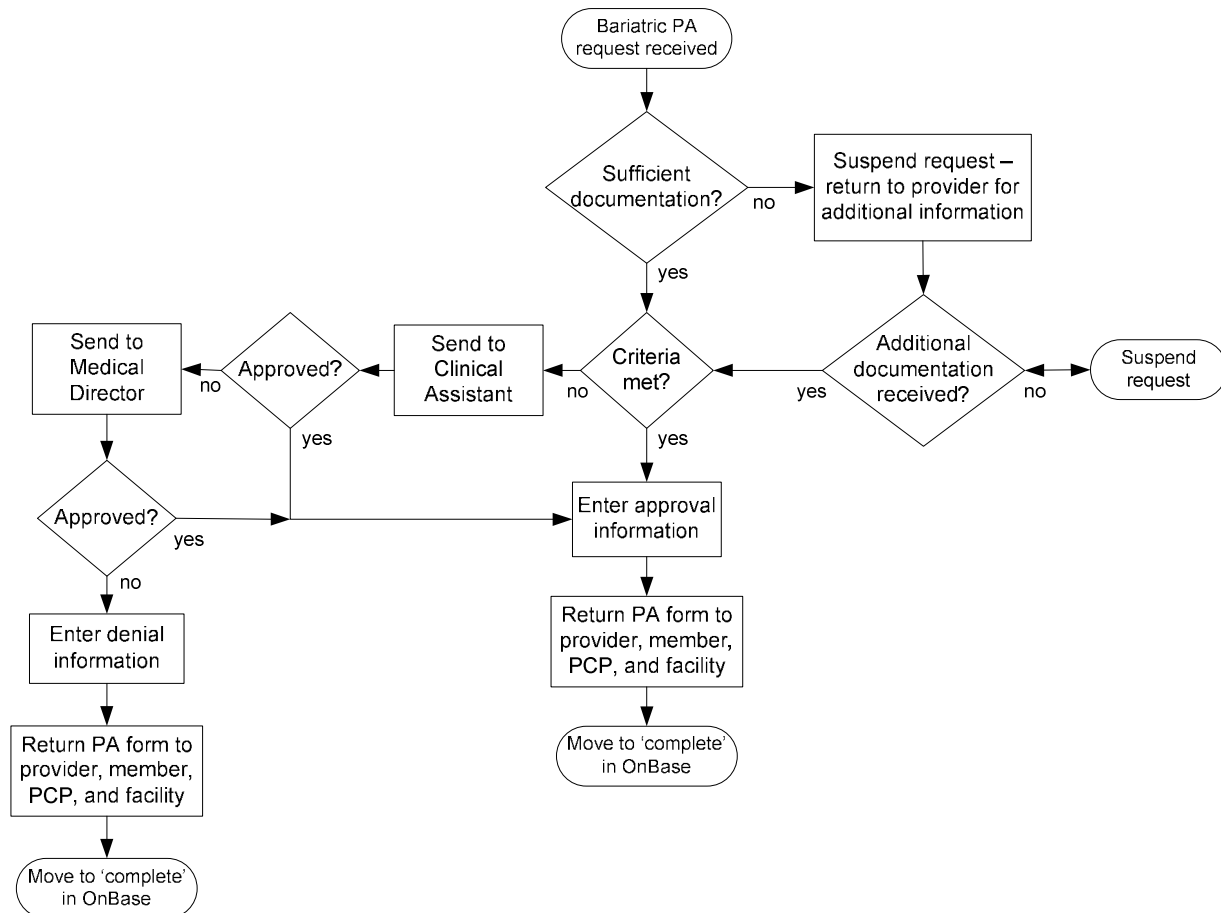
Attachment A:

Transplant Review



Attachment B:

Bariatric Review



Attachment C:

Peer Review

